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The Patient's Own Health Data Repository and Discharge Letters

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Abstract. Discharge letters could be sent to the patients. This poster explores pros and cons of such a procedure.

Keywords. Personal health record, health information architecture, telehealth, discharge letter

1. Introduction and Methods

The medical specialist's discharge letter is a summary of the essential information that must be available for further treatment, management, follow up and for reference. The importance of discharge letters for the health repository of the patient is recognized in the United Kingdom [1] and Australia [2] but efforts to realize that have not yet been sufficiently effective [3]. Two hypothetical case studies were used to detail the different approaches [4,5].

2. Results and Discussion

Figure 1 shows how for a citizen (named Fatima) the data from previous hospital visits can be transferred for a later hospital visit (specialist) through Fatima's own data repository.

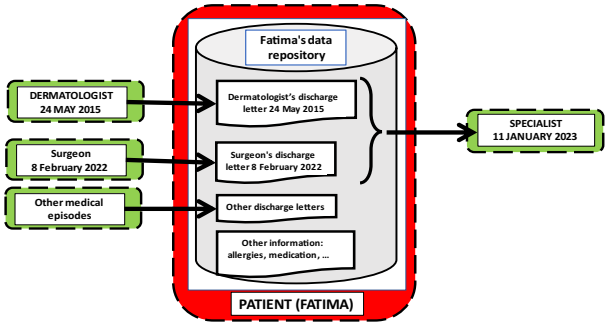

Figure 1. Patient-centered information architecture: transport of the discharge letter to the patient and from the patient

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We compare this information transfer with another hypothetical case, a citizen called Kofi. For Fatima and Kofi the medical data are the same, but for Kofi the medical information architecture that was not patient-centered (Figure 2).

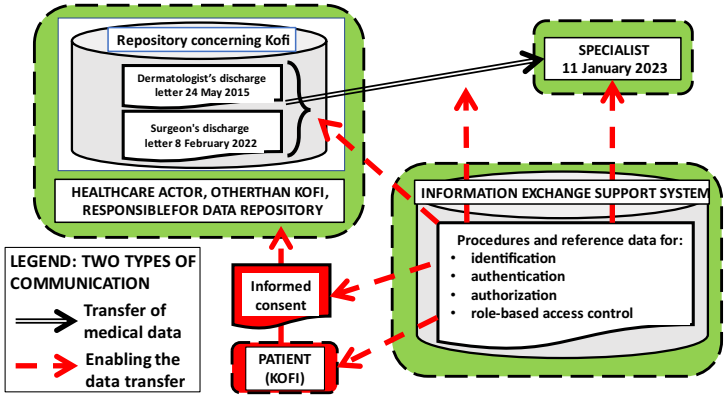

Figure 2 Not-patient-centered information architecture: the transfer of discharge letters from the data repository to a specialist

An advantage of the patient's own health data repository is its simplicity.

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